



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL SAN ANTONIO
4243 E SOUTHCROSS BLVD
SAN ANTONIO TX 78222-3727

Respondent Name

VIA METROPOLITAN TRANSIT

Carrier's Austin Representative Box

Box Number 16

MFDR Tracking Number

M4-10-4688-01

MFDR Date Received

July 12, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital no choice but to seek medical fee dispute resolution"

Amount in Dispute: \$38,227.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In summary, no additional allowance is recommended since the dispute was not submitted in a timely manner and there is no provision for stop loss."

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243-2055

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2009 to July 11, 2009	Outpatient Hospital Services	\$38,227.25	\$5,004.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §102.3 sets forth general provisions regarding the computation of time.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s) /Procedure is included in the value of another service/procedure billed on the same date.*

- W1KA – Workers Compensation State Fee Schedule Adjustment*Reimbursement per the Hospital Facility Fee Guideline-Outpatient Rule 134.403.*
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did the requestor timely file the request for medical fee dispute resolution?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." Per 28 Texas Administrative Code §102.3(a)(3), "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on dates of service July 10, 2009 through July 11, 2009 was received by the Division on July 12, 2010. This date is later than one year after the dates of service in dispute. However, the Division notes that July 10 and July 11, 2010 fell on a Saturday and Sunday, respectively, and were not working days per §102.3(a)(3). The next working day was Monday, July 12, 2010. The Division therefore concludes that the request for dispute resolution was submitted in accordance with the timely filing requirements of §133.307(c).
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. For the purpose of calculating outlier payments, per §134.403(f)(2), the facility's total billed charges shall be reduced by the billed charges for any implantable items that are separately reimbursed.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 99070 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Medical supplies are typically packaged items for which payment is included in the payment for other services performed on the same day. Review of the submitted documentation finds that procedure code 99070 is not supported; separate reimbursement is not recommended.
 - Procedure code 94664 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0077, which, per OPPS Addendum A, has a payment rate of \$26.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.95. This amount multiplied by the annual wage index

for this facility of 0.8917 yields an adjusted labor-related amount of \$14.22. The non-labor related portion is 40% of the APC rate or \$10.63. The sum of the labor and non-labor related amounts is \$24.85. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.308. This ratio multiplied by the billed charge of \$175.00 yields a cost of \$53.90. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$24.85 divided by the sum of all APC payments is 41.69%. The sum of all packaged costs is \$12,392.60. The allocated portion of packaged costs is \$5,167.05. This amount added to the service cost yields a total cost of \$5,220.95. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$5,177.46. 50% of this amount is \$2,588.73. The total APC payment for this service, including outliers, is \$2,613.58. This amount multiplied by 130% yields a MAR of \$3,397.66.

- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0367, which, per OPPS Addendum A, has a payment rate of \$37.17. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.30. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of \$19.88. The non-labor related portion is 40% of the APC rate or \$14.87. The sum of the labor and non-labor related amounts is \$34.75. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.308. This ratio multiplied by the billed charge of \$120.00 yields a cost of \$36.96. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$34.75 divided by the sum of all APC payments is 58.31%. The sum of all packaged costs is \$12,392.60. The allocated portion of packaged costs is \$7,225.55. This amount added to the service cost yields a total cost of \$7,262.51. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$7,201.70. 50% of this amount is \$3,600.85. The total APC payment for this service, including outliers, is \$3,635.60. This amount multiplied by 130% yields a MAR of \$4,726.29.
 - Procedure code 99218 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Payment for hospital observation services provided during the global surgical period is included in the global surgical fee; separate reimbursement is not recommended.
 - Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include: "BARD MESH PERFIX PLUG X-LG" as identified in the itemized statement, "20 cm circular mesh" as identified in the operative report, and labeled on the invoice as "Polyester 8" Round" with a cost per unit of \$1,032.76. The total net invoice amount (exclusive of rebates and discounts) is \$1,032.76. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$103.28. The total recommended reimbursement amount for the implantable items is \$1,136.04.
5. The total recommended payment for the services in dispute is \$9,259.98. This amount less the amount previously paid by the insurance carrier of \$4,255.86 leaves an amount due to the requestor of \$5,004.12.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$5,004.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$5,004.12, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	<u>Grayson Richardson</u> Medical Fee Dispute Resolution Officer	<u>September 7, 2012</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.